SERFF Tracking Number:	*LCNC-128350390*	*State:*	*Arkansas*
Filing Company:	*The Lincoln National Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*B62_5-12, B63_5-12, B66_5-12, B10494_5-12*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*MIB update (COLI APPLICATIONS AND CONSENTS)*		
Project Name/Number:	*MIB update (COLI APPLICATIONS AND CONSEN/B62_5-12, B63_5-12, B66_5-12, B10494_5-12*		

Filing at a Glance

Company: The Lincoln National Life Insurance Company

Product Name: MIB update (COLI APPLICATIONS AND CONSENTS)	SERFF Tr Num: LCNC-128350390	State: Arkansas
TOI: L08 Life - Other	SERFF Status: Closed-Approved-Closed	State Tr Num:
Sub-TOI: L08.000 Life - Other	Co Tr Num: B62_5-12, B63_5-12, B66_5-12, B10494_5-12	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Authors: Raymond Fortier, Renee Gardner, Randi Johnson	Disposition Date: 05/17/2012
	Date Submitted: 05/11/2012	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: MIB update (COLI APPLICATIONS AND CONSEN	Status of Filing in Domicile: Pending
Project Number: B62_5-12, B63_5-12, B66_5-12, B10494_5-12	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 05/17/2012
	State Status Changed: 05/17/2012
Deemer Date:	Created By: Randi Johnson
Submitted By: Renee Gardner	Corresponding Filing Tracking Number:

Filing Description:

Hon. Jay Bradford, Commissioner of Insurance
Compliance-Life & Health
Attn: Joe Musgrove
1200 West Third Street
Little Rock, AR 72201-1904

The Lincoln National Life Insurance Company

SERFF Tracking Number:	*LCNC-128350390*	*State:*	*Arkansas*
Filing Company:	*The Lincoln National Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*B62_5-12, B63_5-12, B66_5-12, B10494_5-12*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*MIB update (COLI APPLICATIONS AND CONSENTS)*		
Project Name/Number:	*MIB update (COLI APPLICATIONS AND CONSEN/B62_5-12, B63_5-12, B66_5-12, B10494_5-12*		

NAIC #65676
FEIN #35-0472300

Re. Life Application Form

B62_5-12 – Executive Benefits Individual Owner Modified Simplified Issue Part I Application for Life Insurance
B63_5-12 – Executive Benefits Individual Owner Part I and Part II Application for Life Insurance
B66_5-12 – Executive Benefits Corporate Owner Application for Life Insurance Part II Application
B10494_5-12 – Modified Simplified Underwriting and Consent Form

Dear Joe Musgrove:

We are submitting the above-referenced forms for your review and approval. The forms have previously been approved in your jurisdiction on 10/6/2011, SERFF Tracking No. LCNC-127401060, State File No. 49695.

The following sentence has been added under the Authorization Section of each form to bring the form into compliance with the MIB required language which must be implemented by January 1, 2013:

“I/We authorize the Company or its reinsurer to make a brief report of my protected health information to MIB, Inc. I/We authorize the Company to disclose information related to my insurability to other insurers to whom I/We may apply for coverage.”

The originally approved form numbers in the lower left hand corner will now have a date extension of “_5-12”. We have enclosed a copy of the original approved forms, highlighting the changes. There have been no other changes to the forms other than those indicated above. Please accept this letter as our certification that the above noted sentence, form number and revision date are the only changes we made to the form.

The forms appear in final printed format as issued from a laser printer. Upon approval, we reserve the right to change the format of a form without altering the approved language, though it is possible page numbers may change.

We have bracketed several items within the form as variable information to allow for flexibility in the content of the form. These items include: company names, the Service Office addresses, form page number references and the questions relating to desired riders. As we may develop new riders in the future we reserve the right to add approved riders to the appropriate section on the application. It is our understanding that changes to the bracketed items for new issues will not require a new filing of this form. We confirm that the brackets will not actually appear on the form at issue.

The forms received the following Flesch scores:
Form: Flesch Score:

SERFF Tracking Number:	*LCNC-128350390*	*State:*	*Arkansas*
Filing Company:	*The Lincoln National Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*B62_5-12, B63_5-12, B66_5-12, B10494_5-12*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*MIB update (COLI APPLICATIONS AND CONSENTS)*		
Project Name/Number:	*MIB update (COLI APPLICATIONS AND CONSEN/B62_5-12, B63_5-12, B66_5-12, B10494_5-12*		

B62_5-12 – Executive Benefits Individual Owner Modified Simplified Issue Part I Application for Life Insurance 50
B63_5-12 – Executive Benefits Individual Owner Part I and Part II Application for Life Insurance 50
B66_5-12 – Executive Benefits Corporate Owner Application for Life Insurance Part II Application 50
B10494_5-12 – Modified Simplified Underwriting and Consent Form 52

This filing has been submitted concurrently to our Home State of Indiana and is pending approval. This submission contains no unusual or possibly controversial items from the standpoint of normal company or industry standards. To the best of our knowledge and belief, these forms comply with all the applicable laws and regulations of your state.

We trust the information provided will be satisfactory and we look forward to your response. Should you require any additional information, please feel free to contact me toll-free at 1-800-238-6252 (ext. 62067) or email address shown below. Thank you for your time and consideration.

Sincerely,

Renee Gardner
Product Compliance Analyst
Phone: 860.466.2067
Email: Renee.Gardner@lfg.com
Enclosures

State Narrative:

Company and Contact

Filing Contact Information

Renee Gardner, Contract Analyst	renee.gardner@lfg.com
350 Church street	860-466-2067 [Phone] 2067 [Ext]
hartford, CT 06103	860-466-1348 [FAX]

Filing Company Information

The Lincoln National Life Insurance Company	CoCode: 65676	State of Domicile: Indiana
350 Church Street - MPM1	Group Code: 20	Company Type: Life
Hartford, CT 06103-1106	Group Name:	State ID Number:
(860) 466-2899 ext. [Phone]	FEIN Number: 35-0472300	

SERFF Tracking Number:	*LCNC-128350390*	*State:*	*Arkansas*
Filing Company:	*The Lincoln National Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*B62_5-12, B63_5-12, B66_5-12, B10494_5-12*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*MIB update (COLI APPLICATIONS AND CONSENTS)*		
Project Name/Number:	*MIB update (COLI APPLICATIONS AND CONSEN/B62_5-12, B63_5-12, B66_5-12, B10494_5-12*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$140.00
Retaliatory?	Yes
Fee Explanation:	Four forms at $35.00 per form
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Lincoln National Life Insurance Company	$140.00	05/11/2012	59113804
The Lincoln National Life Insurance Company	$60.00	05/15/2012	59166477

SERFF Tracking Number:	*LCNC-128350390*	*State:*	*Arkansas*
Filing Company:	*The Lincoln National Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*B62_5-12, B63_5-12, B66_5-12, B10494_5-12*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*MIB update (COLI APPLICATIONS AND CONSENTS)*		
Project Name/Number:	*MIB update (COLI APPLICATIONS AND CONSEN/B62_5-12, B63_5-12, B66_5-12, B10494_5-12*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	05/17/2012	05/17/2012

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Linda Bird	05/14/2012	05/14/2012	Renee Gardner	05/16/2012	05/16/2012

SERFF Tracking Number:	*LCNC-128350390*	*State:*	*Arkansas*
Filing Company:	*The Lincoln National Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*B62_5-12, B63_5-12, B66_5-12, B10494_5-12*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*MIB update (COLI APPLICATIONS AND CONSENTS)*		
Project Name/Number:	*MIB update (COLI APPLICATIONS AND CONSEN/B62_5-12, B63_5-12, B66_5-12, B10494_5-12*		

Disposition

Disposition Date: 05/17/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*LCNC-128350390*	*State:*	*Arkansas*
Filing Company:	*The Lincoln National Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*B62_5-12, B63_5-12, B66_5-12, B10494_5-12*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*MIB update (COLI APPLICATIONS AND CONSENTS)*		
Project Name/Number:	*MIB update (COLI APPLICATIONS AND CONSEN/B62_5-12, B63_5-12, B66_5-12, B10494_5-12*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Form	Executive Benefits Individual Owner Modified Simplified Issue Part I Application for Life Insurance		Yes
Form	Executive Benefits Individual Owner Part I and Part II Application for Life Insurance		Yes
Form	Executive Benefits Corporate Owner Application for Life Insurance Part II Application		Yes
Form	Modified Simplified Underwriting and Consent Form		Yes

SERFF Tracking Number:	*LCNC-128350390*	*State:*	*Arkansas*
Filing Company:	*The Lincoln National Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*B62_5-12, B63_5-12, B66_5-12, B10494_5-12*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*MIB update (COLI APPLICATIONS AND CONSENTS)*		
Project Name/Number:	*MIB update (COLI APPLICATIONS AND CONSEN/B62_5-12, B63_5-12, B66_5-12, B10494_5-12*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	05/14/2012
Submitted Date	05/14/2012
Respond By Date	06/14/2012

Dear Renee Gardner,

This will acknowledge receipt of the captioned filing.

Objection 1
Comment: Regulation 57 was revised effective January 2010, the filing fee is now $50.00 per form. We will hold your filing in a pending status until the additional $60.00 is received.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.
Sincerely,
Linda Bird

SERFF Tracking Number:	*LCNC-128350390*	*State:*	*Arkansas*
Filing Company:	*The Lincoln National Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*B62_5-12, B63_5-12, B66_5-12, B10494_5-12*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*MIB update (COLI APPLICATIONS AND CONSENTS)*		
Project Name/Number:	*MIB update (COLI APPLICATIONS AND CONSEN/B62_5-12, B63_5-12, B66_5-12, B10494_5-12*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	05/16/2012
Submitted Date	05/16/2012

Dear Linda Bird,

Comments:
Thank you for the information regarding the new fees.

Response 1

Comments: We have added the additional fees.

Related Objection 1

Comment:
Regulation 57 was revised effective January 2010, the filing fee is now $50.00 per form. We will hold your filing in a pending status until the additional $60.00 is received.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thank you for your assistance in this matter.

Sincerely,
Randi Johnson, Raymond Fortier, Renee Gardner

SERFF Tracking Number:	*LCNC-128350390*	*State:*	*Arkansas*
Filing Company:	*The Lincoln National Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*B62_5-12, B63_5-12, B66_5-12, B10494_5-12*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*MIB update (COLI APPLICATIONS AND CONSENTS)*		
Project Name/Number:	*MIB update (COLI APPLICATIONS AND CONSEN/B62_5-12, B63_5-12, B66_5-12, B10494_5-12*		

Form Schedule

Lead Form Number: B62_5-12, B63_5-12, B66_5-12, B10494_5-12

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	B62_5-12	Application/ Enrollment Form	Executive Benefits Individual Owner Modified Simplified Issue Part I Application for Life Insurance	Other	Other Explanation: MIB language update	50.000	B62_5-12-Bracketed-Highlighted.pdf
	B63_5-12	Application/ Enrollment Form	Executive Benefits Individual Owner Part I and Part II Application for Life Insurance	Other	Other Explanation: MIB language update	50.000	B63_5-12-Bracketed-Highlighted.pdf
	B66_5-12	Application/ Enrollment Form	Executive Benefits Corporate Owner Application for Life Insurance Part II Application	Other	Other Explanation: MIB language update	50.000	B66_B_5-12-Bracketed-Highlighted.pdf
	B10494_5-12	Application/ Enrollment Form	Modified Simplified Underwriting and Consent Form	Other	Other Explanation: MIB language update	52.000	B10494_B_5-12-Bracketed-Highlighted.pdf

Executive Benefits Individual Owner Modified Simplified Issue Part I Application for Life Insurance

Lincoln Financial Group℠

B62_5-12
(Standard Version)

The Lincoln National Life Insurance Company
Service Office: [350 Church St., - MEM4
Hartford, CT 06103-1106]
(hereinafter referred to as "the Company")

IMPORTANT NOTICE
Since you are applying for insurance, we would like you to know more about our underwriting process and what occurs after you submit your application.

(Please give a copy of these notices to the Proposed Insured.)

THE UNDERWRITING PROCESS

All forms of insurance are based on the concept of risk-sharing. Underwriters seek to determine the level of risk represented by each applicant, and then assign that person to a group with similar risk characteristics. In this way, the risk potential can be spread among all policyholders within a given risk group, assuring that each assumes his fair share of the insurance cost.

Underwriters collect and review risk factors such as age, occupation, physical condition, medical history and any hazardous avocations. The level of risk and premium for the amount of coverage requested is based on this information.

INVESTIGATIVE CONSUMER REPORT

As a part of our routine procedure for processing your initial application, we may request an investigative consumer report. The agency making the report may keep a copy of the report and disclose its contents to others for whom it performs similar services. The report typically includes information such as identity and residence verification, character, reputation, marital status, estimate of net worth and income, occupation, avocations, medical history, habits, mode of living and other personal aracteristics. Additional information is usually obtained from several different sources. Confidential interviews are conducted with neighbors, friends, business associates, and acquaintances. Public records are carefully reviewed.

Past experience shows that information from investigative reports usually does not have an adverse effect on our underwriting decision. If it should, we will notify you in writing and identify the reporting agency. At that point, if you wish to do so, you may discuss the matter with the reporting agency.

You have the right to be interviewed as part of any investigative consumer report that is completed. If you desire such an interview, please indicate this at the time your application is submitted. If you request it, we will supply the name, address and telephone number of the consumer reporting agency so you may obtain a copy of the report.

CONTESTABILITY

We strongly urge you to review the completed application closely for accuracy. During the 2 year incontestability period described in the policy, a claim may be denied if the application contains false statements or misrepresentations or fails to disclose material facts. In such a case, the policy could be void and coverage could be lost.

MIB, INC.

Information you provide regarding your insurability or claims will be treated as confidential except that The Company or its reinsurers, may make a brief report of it to MIB, Inc. This is a nonprofit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or submitted a claim, MIB, Inc. will provide the information it may have in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB at: [50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734]. You can reach MIB by phone toll free at [(866) 692-6901. (TTY {866} 346-3642)]

Lincoln Financial Group℠

The Lincoln National Life Insurance Company
Executive Benefits Individual Owner Modified Simplified Issue
Part I Application for Life Insurance
[350 Church St., - MEM4
Hartford, CT 06103-1106]
(hereinafter referred to as "the Company")

CORPORATION INFORMATION

1. Corporation Name	2. Taxpayer Identification Number
3. Address *(Street, City, State, ZIP)*	

PLAN ADMINISTRATION CONTACT *(Send all correspondence to named contact in Brokers Office of Servicing Agent)*

4. Name	5. Telephone Number *(include area code)*
6. Address *(Street, City, State, ZIP)*	

PROPOSED INSURED INFORMATION

7. Proposed Insured *(First, Middle Initial, Last)*			8. Place of Birth	
9. Are you a citizen of the United States? ☐ Yes ☐ No (If "No", please provide country, type of visa, expiration date and green card information): _____				
10. Date of Birth *(mm/dd/yy)*	11. Social Security Number	12. ☐ Male ☐ Female	13. Driver's License # & State	
14. Occupation		15. Salary $	16. Date of Hire *(mm/dd/yy)*	
17. Home Address *(No., Street, PO Box, City, State, ZIP)*				

ELIGIBILITY INFORMATION FOR PROPOSED INSURED

18. Have you been actively at work on a full time basis (at least 30 hours/week) performing all duties of your regular occupation, at your customary place of employment for the past 3 months? (Disregard vacation days, normal non-working days and absences that total less than 4 consecutive days). If "No", specify:_____	☐ Yes ☐ No
19. Have you ever used tobacco or products containing nicotine (including, but not limited to, chew tobacco, snuff, nicotine gum and/or patches)? *(If "Yes", list below.)*	☐ Yes ☐ No

Type	Date First Used: *(month/year)*	Date Last Used: *(month/year)*	Amount and Frequency:

20. Have you, in the past 10 years been treated by a licensed medical professional for any disorder of the heart or blood vessels, tumors or cancer, diabetes, stroke or any disorder of the blood, lungs, kidneys, drug or alcohol use, depression or been diagnosed as having or been treated by a licensed medical professional for Acquired Immune Deficiency (AIDS) or AIDS related condition? If "Yes", explain:_____	☐ Yes ☐ No

OWNER DESIGNATION *(Select One - Please complete this section if the Insured is not the Owner)*

21. ☐ Insured ☐ Trust (Name of Trust, Trustee and Date of Trust) ☐ Other: _____

22. Owner Name	23. Taxpayer Identification/Social Security Number
24. Address *(Street, City, State, ZIP)*	
25. Name of Trustee	26. Date of Trust

PAYOR DESIGNATION *(Please complete if the Payor is other than the Owner)*

27. Payor Name

28. Address *(Street, City, State, ZIP)*

BENEFICIARY DESIGNATION *(Select One)*

29. ☐ Individual *(Provide Full Name, Social Security Number and Relationship)*

Primary _____ _____ % SSN: _____ Relationship to Insured: _____

Address *(Street, City, State, ZIP)* _____

Primary _____ _____ % SSN: _____ Relationship to Insured: _____

Address *(Street, City, State, ZIP)* _____

30.

Contingent _____ _____ % SSN: _____ Relationship to Insured: _____

Contingent _____ _____ % SSN: _____ Relationship to Insured: _____

31. ☐ Trust *(Name of Trust, Trustee and Date of Trust)* ☐ Primary ☐ Contingent TIN: _____

32. ☐ Split Dollar *(Enclose a copy of split dollar agreement)* ☐ Primary ☐ Contingent

33. ☐ Other: ☐ Primary ☐ Contingent

POLICY INFORMATION

34. Requested Policy Effective Date	35. Billing Frequency ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly ☐ Single Premium	
36. Basic Plan ☐ Corporate Universal Life _____ ☐ Corporate Variable Universal Life _____	37. Death Benefit Option ☐ 1 ☐ 2 ☐ 3	38. [A.B.E. Allocations, if elected Year 1 _____ Year 2 _____ Year 3 _____ Year 4 _____ Year 5 _____ Year 6 _____ Year 7+ _____ See attached schedule if more than 7 years.]
39. ☐ Guideline Premium Test ☐ Cash Value Accumulation Test	40. Planned Premium Funding Schedule ☐ Number of Years _____ ☐ Pay to Age _____	41. [Other Rider(s) Selected Term %_____ _____ _____ Loan Spread Rider, if elected ☐ Option 1 ☐ Option 2 ☐ Option 3]
42. Coverage Information: *(Select one)* Specified Amount $_____ ☐ See attached Census		

OTHER INSURANCE ON PROPOSED INSURED

43. Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefit under an existing policy or annuity, or are you considering using or borrowing funds from your existing policies or annuities to pay premiums due on the new or applied for policy? ☐ Yes ☐ No _____
(If "Yes", please complete and sign all replacement forms.)

44. Amount all life insurance presently in force or applied for. **If none, check this box:** ☐
Please indicate the Type of coverage: Business (**B**); Key Person (**K**); or Personal (**P**).

Company	Face Amount	Policy Number	Issue Date *(mm/dd/yy)*	Replacement or Change of Policy?	1035 Exchange	Type
	$			☐ Yes ☐ No	☐ Yes ☐ No	
	$			☐ Yes ☐ No	☐ Yes ☐ No	
	$			☐ Yes ☐ No	☐ Yes ☐ No	
	$			☐ Yes ☐ No	☐ Yes ☐ No	
	$			☐ Yes ☐ No	☐ Yes ☐ No	
	$			☐ Yes ☐ No	☐ Yes ☐ No	

Please attach a list of any other additional insurance on a separate sheet. What is the total amount of new life insurance coverage that will be placed in force with all companies including this application? $ _____

SERVICE OFFICE ENDORSEMENTS *(For Company Use Only. We will attach additional documentation as needed.)*

TRUST VERIFICATION

I/We hereby certify that the Trustee(s) named in this application are the Trustee(s) for the named Trust, which is in full force and effect. The Company assumes no obligation to inquire into the terms of any trust agreement affecting this policy and shall not be held liable for any party's compliance with the terms thereof. The Company may rely solely upon the signature(s) of the Trustee(s) named in this application to any receipt, release or waiver, or to any transfer or other instrument affecting this policy or any options, privileges or benefits thereunder. Unless otherwise indicated, the signature(s) of all Trustee(s) named, or their successors, will be required to exercise any contractual right under the policy. The Company shall have no obligation to see to the use or application of any funds paid to the Trustee(s) in accordance with the terms of the policy. Any such payment made by the Company to the Trustee(s) shall fully discharge the Company with respect to any amounts so paid.

SUITABILITY - COMPLETE THIS SECTION IF VUL *ONLY*

1. Have you, the Proposed Insured and the Owner, received a current Prospectus, or equivalent document for the policy applied for and have you had sufficient time to review?	☐ Yes ☐ No
2. Do you understand that the amount and duration of the death benefit may increase or decrease depending on the investment performance of funds in the Separate Account?	☐ Yes ☐ No
3. Do you understand that the cash value may increase or decrease depending on the investment performance of the funds held in the Separate Account?	☐ Yes ☐ No
4. With this in mind, do you believe that the policy applied for is in accord with your insurance objective and your anticipated financial needs?	☐ Yes ☐ No

CASH VALUES MAY INCREASE OR DECREASE IN ACCORDANCE WITH THE EXPERIENCE OF THE SEPARATE ACCOUNT. THE DEATH BENEFIT MAY BE VARIABLE OR FIXED UNDER SPECIFIED CONDITIONS.

STATE DISCLOSURE

Any person who, with intent to defraud or knowing that he/she is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

AGREEMENT AND ACKNOWLEDGEMENT

Under penalties of perjury I, the undersigned, certify that: (a) the tax identification or social security numbers as provided by me is correct; and (b) the holders of said numbers are not subject to any backup withholding of U.S. Federal income tax.

Each of the Undersigned declares that:

1. This Application consists of: a) this Executive Benefits Individual Owner Modified Simplified Part I Application; b) any amendments to the application attached thereto; and c) any supplements, all of which are required by the Company for the plan, amount and benefits applied for. The Executive Benefits Individual Owner Modified Simplified Part I Application is fully completed.
2. I/We further agree that coverage will take effect under the Policy only when: 1) initial premium payment has been received; 2) the initial premium has been paid in full during the lifetime of the Proposed Insured; and 3) the Proposed Insured remains in the same state of health and insurability as described in each part of the application at the time conditions 1) and 2) are met.
3. If this is a request to exercise an option in an existing policy, the request will become effective in accordance with the terms of that option. If this is a request for change, any and all values may be used to pay for the change and to repay any loan indebtedness. The changed policy will be subject to any loan indebtedness not repaid. Any assignment in effect at the time of this request will apply to any new insurance issued.
4. No agent, broker or medical examiner has the authority to make changes or modify any Company contract or to waive any of the Company's requirements.
5. I HAVE READ, or have had read to me, the completed Application before signing. All statements and answers in this application are correctly recorded, and are full, complete and true. I confirm that upon receipt of the contract I will review the answers recorded on the application. I will notify the Company immediately if any information in the application is incorrect. Caution: If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or rescind coverage under the policy and any riders attached to it.
6. Corrections, additions or changes to this application may be made by the Company. Any such changes will be shown under "Service Office Endorsements". Acceptance of a policy issued with such changes will constitute acceptance of the changes. No change will be made in classification (including age at issue), plan, amount, or benefits unless agreed to in writing by the Applicant.

AUTHORIZATION

Each of the undersigned declares that:

I/We authorize any medical professional, hospital or other medical institution, insurer, MIB, Inc., or any other person or organization that has any records or knowledge of me or my physical or mental health or insurability to disclosure that information to the Company, its reinsurers or any other party acting on the Company's behalf. I/We authorize the Company or its reinsurer to make a brief report of my protected health information to MIB, Inc. I/We authorize the Company to disclose information related to my insurability to other insurers to whom I/we may apply for coverage.

I/We acknowledge receipt of the Privacy Notice and the Important Notice containing the Investigative Consumer Report and MIB, Inc. information.

This authorization shall be valid for 24 months after it is signed. A photographic copy of this authorization shall be as valid as the original. I/We understand that I/we may revoke this authorization at any time by written notification to the Company; however, any action taken prior to notification will not be affected.

The purpose of this authorization is to allow the Company to determine eligibility for life coverage or a claim for benefits under a life policy.

☐ I elect to be interviewed if an Investigative Consumer Report is prepared.

SIGNATORY SECTION

Signature of Proposed Insured **Date**

Signature of Applicant/Owner/Trustee **Date**

Signed at (City and State)

1) Based on information obtained from the Owner, I believe the investment is suitable for the Owner's objectives.
2) To the best of my knowledge, the source of funding for this policy does not include: (1) a non-recourse premium financing loan; or (2) any arrangement, other than a premium financing loan, which involves any person or entity with an interest in the potential for earnings based on the provision of funding for the policy.
3) Does the applicant have any existing life insurance policies or annuities? ☐ Yes ☐ No
4) Do you know or have you any reason to believe that replacement of insurance is involved? ☐ Yes ☐ No
   If a replacement is involved, I certify that only company approved sales materials were used in this sale and that copies of all sales materials were left with the applicant.

I declare that I have accurately answered all questions contained in this section.

I declare that I have provided each Proposed Insured and Owner(s) with the Important Notice as well as a copy of the Privacy Practices Notice.

Signature of Broker, Agent or Licensed Representative **Name of Broker, Agent or Licensed Representative** (Please Print) **Date**

Executive Benefits Individual Owner Part I and Part II Application for Life Insurance

B63_5-12
(Standard Version)

The Lincoln National Life Insurance Company
Service Office: [350 Church St., - MEM4
Hartford, CT 06103-1106]
(hereinafter referred to as "the Company")

IMPORTANT NOTICE
Since you are applying for insurance, we would like you to know more about our underwriting process and what occurs after you submit your application.

(Please give a copy of these notices to the Proposed Insured.)

THE UNDERWRITING PROCESS

All forms of insurance are based on the concept of risk-sharing. Underwriters seek to determine the level of risk represented by each applicant, and then assign that person to a group with similar risk characteristics. In this way, the risk potential can be spread among all policyholders within a given risk group, assuring that each assumes his fair share of the insurance cost.

Underwriters collect and review risk factors such as age, occupation, physical condition, medical history and any hazardous avocations. The level of risk and premium for the amount of coverage requested is based on this information.

INVESTIGATIVE CONSUMER REPORT

As a part of our routine procedure for processing your initial application, we may request an investigative consumer report. The agency making the report may keep a copy of the report and disclose its contents to others for whom it performs similar services. The report typically includes information such as identity and residence verification, character, reputation, marital status, estimate of net worth and income, occupation, avocations, medical history, habits, mode of living and other personal aracteristics. Additional information is usually obtained from several different sources. Confidential interviews are conducted with neighbors, friends, business associates, and acquaintances. Public records are carefully reviewed.

Past experience shows that information from investigative reports usually does not have an adverse effect on our underwriting decision. If it should, we will notify you in writing and identify the reporting agency. At that point, if you wish to do so, you may discuss the matter with the reporting agency.

You have the right to be interviewed as part of any investigative consumer report that is completed. If you desire such an interview, please indicate this at the time your application is submitted. If you request it, we will supply the name, address and telephone number of the consumer reporting agency so you may obtain a copy of the report.

CONTESTABILITY

We strongly urge you to review the completed application closely for accuracy. During the 2 year incontestability period described in the policy, a claim may be denied if the application contains false statements or misrepresentations or fails to disclose material facts. In such a case, the policy could be void and coverage could be lost.

MIB, INC.

Information you provide regarding your insurability or claims will be treated as confidential except that The Company or its reinsurers, may make a brief report of it to MIB, Inc. This is a nonprofit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or submitted a claim, MIB, Inc. will provide the information it may have in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB at: [50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734]. You can reach MIB by phone toll free at [(866) 692-6901. (TTY {866} 346-3642)]

Lincoln Financial Group℠

The Lincoln National Life Insurance Company
Executive Benefits Individual Owner Part I and Part II Application for Life Insurance
[350 Church St., - MEM4
Hartford, CT 06103-1106]
(hereinafter referred to as "the Company")

CORPORATION INFORMATION

1. Corporation Name	2. Taxpayer Identification Number
3. Address *(Street, City, State, ZIP)*	

PLAN ADMINISTRATION CONTACT *(Send all correspondence to named contact in Brokers Office of Servicing Agent)*

4. Name	5. Telephone Number *(include area code)*
6. Address *(Street, City, State, ZIP)*	

PROPOSED INSURED INFORMATION

7. Proposed Insured *(First, Middle Initial, Last)*			8. Place of Birth
9. Are you a citizen of the United States? ☐ Yes ☐ No (If "No", please provide country, type of visa, expiration date and green card information) _____			
10. Date of Birth *(mm/dd/yy)*	11. Social Security Number	12. ☐ Male ☐ Female	13. Driver's License # & State
14. Occupation		15. Salary $	16. Date of Hire *(mm/dd/yy)*
17. Home Address *(No., Street, PO Box, City, State, ZIP)*			

GENERAL RISK INFORMATION For Proposed Insured

If you answer "No" to question 18, or "Yes" to questions 21-24, explain in the space provided on Page 2.

	Yes	No
18. Have you been actively at work on a full time basis (at least 30 hours/week) performing all duties of your regular occupation, at your customary place of employment for the past 3 months? (Disregard vacation days, normal non-working days and absences that total less than 4 consecutive days). If "No", specify: _____	☐	☐
19. Have you ever used tobacco or products containing nicotine (including, but not limited to, chew tobacco, snuff, nicotine gum and/or patches)? *(If "Yes", list below.)*	☐	☐

Type	Date First Used: *(month/year)*	Date Last Used: *(month/year)*	Amount and Frequency:

	Yes	No
20 a. Do you now, or do you plan to fly, or have you flown during the past 2 years, as a pilot, student pilot or crew member? *(If "Yes", an Aviation Supplement is required; this includes balloon pilots.)*	☐	☐
b. Do you plan to participate, or have you participated within the past 2 years; in motor vehicle or boat racing, in hang gliding, sky or scuba diving, or mountain, rock or technical climbing; or in similar sports? *(If "Yes", an Avocation Supplement is required.)*	☐	☐
c. Do you now, or do you plan to reside or travel outside of the United States or Canada within the next year? *(If "Yes", a Foreign Travel or Residence Supplement is required.)*	☐	☐

GENERAL RISK INFORMATION For Proposed Insured (Continued)

	Yes	No
21. In the past 5 years, have you been convicted of two or more moving violations, driving under the influence of alcohol or other drugs, or had your driver's license suspended, revoked or restricted? *(If "Yes," please provide what type and dates in the "Details" space provided.)*	☐	☐
22. Have you ever applied for any life, health or disability insurance which was denied, postponed, required an extra premium or was issued for a reduced amount? *(If "Yes", please provide what type and dates in the "Details" space provided.)*	☐	☐
23. Have you ever been convicted or are you waiting trial for a felony? *(If "Yes", please indicate type, date and city/state of felony and if currently on probation or parole in the "Details" space provided.)*	☐	☐
24. Are you a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? *(If "Yes", please indicate if Retired or Active; list branch of service, rank, duties, mobilization category and current duty station; if a notice of deployment has been received, to where and when; in the "Details" space provided.)*	☐	☐

25. **Details:** *(If you answered "No" to question 18 or "Yes" to question 21-24 list details in this section; please include question number details pertain to and attach an additional sheet of paper, if necessary.)*

MEDICAL RISK INFORMATION For Proposed Insured

If you answer "Yes" to any of the following questions, please provide further information in the "Details" space provided on page 3.

26. **Have you ever had an indication of, or been treated by a licensed medical professional for:**	Yes	No
a. Chest pain, palpitations, high blood pressure, heart disease, heart murmur, heart failure or other disorders of the heart or blood vessels?	☐	☐
b. Any tumor, cancer, cysts, melanoma, lymphoma or any disorder of the lymph nodes?	☐	☐
c Anemia, leukemia, clotting disorder or any other blood disorder?	☐	☐
d. Diabetes, elevated blood sugar, thyroid, or other endocrine or glandular disorder?	☐	☐
e. Asthma, emphysema, allergies, sleep apnea, tuberculosis, sarcoidosis, persistent hoarseness or shortness of breath or any other disorder of the respiratory system?	☐	☐
f. Seizures, fainting, dizziness, epilepsy, stroke, paralysis or other neurologic or brain disorder?	☐	☐
g. Any nervous, mental, or emotional disorder, or received counseling for anxiety, depression, stress or any other emotional condition?	☐	☐
h. Ulcers, colitis, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disorder of the stomach, esophagus, liver, intestines, gallbladder, or pancreas?	☐	☐
i. Any complication of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney or urinary bladder?	☐	☐
j. Arthritis, gout or any disorder of the back, spine, muscles, nerves, bones or joints or skin?	☐	☐
k. Any disorder of the eyes, ears, nose or throat?	☐	☐
l. Any mental or physical disorder medically or surgically treated condition not listed above?	☐	☐
27. Have you ever been diagnosed as having or been treated by a licensed medical professional for Acquired Immuno Deficiency Syndrome or an AIDS related condition?	☐	☐
28. Do you use alcoholic beverages? *(If "Yes", Provide type, Frequency & Amount)* Type _____ Frequency _____ Amount _____	☐	☐
29. Have you ever been treated for drug or alcohol abuse or been advised by a licensed medical professional to limit your use of alcohol or any medication, prescribed or not?	☐	☐
30. In the past 5 years have you ever used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics?	☐	☐
31. Have you had or been advised by a licensed medical professional to have a check-up, EKG, x-ray, blood or urine test or any other diagnostic test or are you now planning to seek medical advice or treatment for any reason?	☐	☐
32. Have you been a patient in a hospital, clinic, sanatorium or other medical facility, or been advised by a licensed medical professional to have any hospitalization or surgery which has not been completed?	☐	☐

33. List all medication and dosages you are currently taking or have taken in the last 30 days, including prescriptions, over the counter drugs, aspirin and herbal supplements: *(Attach an additional sheet of paper, if necessary.)*

DETAILS TO MEDICAL RISK INFORMATION QUESTIONS 26-32, if answered "Yes", please specify below.

34. Number, nature and severity of condition, frequency of attacks, treatments received medication, dates, name, address & phone number of medical attendants and hospitals. (List details from "Yes" answered Medical Information; please include question number. *Attach an additional sheet of paper, if necessary.)*

Ques.	Details

MEDICAL INFORMATION For Proposed Insured

35 a. Provide full name/address/phone number of personal physician(s) and any other physicians seen within the past 5 years.

b. Date and reason of last visit:

c. Tests performed & treatment received:

36. Height _____ ft. / _____ in. a. Has your weight changed by more than 10 pounds during the past 12 months? ☐ Y ☐ N
Weight _____ lbs. b. If "Yes," by how many pounds? _____ ☐ Gain ☐ Loss

37.	Age if Living & Health Status	Diabetes, Cancer, Heart Disease? *(include age of onset)*	Age at Death & Cause
a. Father			
b. Mother			
c. Sibling(s)			

OWNER DESIGNATION ***(Select One - Please complete this section if the Insured is not the Owner)***

38. ☐ Insured ☐ Trust (Name of Trust, Trustee and Date of Trust) ☐ Other: _____

39. Owner Name	40. Taxpayer Identification/Social Security Number
41. Address *(Street, City, State, ZIP)*	
42. Name of Trustee	43. Date of Trust

PAYOR DESIGNATION ***(Please complete if the Payor is other than the Owner)***

44. Payor Name

45. Address *(Street, City, State, ZIP)*

BENEFICIARY DESIGNATION *(Select One)*

46. ☐ Individual *(Provide Full Name, Social Security Number and Relationship)*

Primary _____ _____ % SSN: _____ Relationship to Insured: _____

Address *(Street, City, State, ZIP)* _____

Primary _____ _____ % SSN: _____ Relationship to Insured: _____

Address *(Street, City, State, ZIP)* _____

47.

Contingent _____ _____ % SSN: _____ Relationship to Insured: _____

Contingent _____ _____ % SSN: _____ Relationship to Insured: _____

48. ☐ Trust *(Name of Trust, Trustee and Date of Trust)* ☐ Primary ☐ Contingent TIN: _____

49. ☐ Split Dollar *(Enclose a copy of split dollar agreement)* ☐ Primary ☐ Contingent

50. ☐ Other: ☐ Primary ☐ Contingent

POLICY INFORMATION

51. Requested Policy Effective Date

52. Billing Frequency
☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly ☐ Single Premium

53. Basic Plan
☐ Corporate Universal Life _____
☐ Corporate Variable Universal Life _____

54. Death Benefit Option
☐ 1 ☐ 2 ☐ 3

55. [A.B.E. Allocations, if Selected
Year 1 _____
Year 2 _____
Year 3 _____
Year 4 _____
Year 5 _____
Year 6 _____
Year 7+ _____
See attached schedule if more than 7 years.]

56. ☐ Guideline Premium Test
☐ Cash Value Accumulation Test

57. Planned Premium Funding Schedule
☐ Number of Years _____
☐ Pay to Age _____

58. [Other Rider(s) Selected
Term %_____
_____
_____
Loan Spread Rider, if Selected
☐ Option 1 ☐ Option 2 ☐ Option 3]

59. Coverage Information: *(Select one)*
Specified Amount $_____ ☐ See attached Census

OTHER INSURANCE ON PROPOSED INSURED

60. Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefit under an existing policy or annuity, or are you considering using or borrowing funds from your existing policies or annuities to pay premiums due on the new or applied for policy? ☐ Yes ☐ No _____
(If "Yes", please complete and sign all replacement forms.)

61. Amount of all life insurance presently in force or applied for. **If none, check this box:** ☐
Please indicate the Type of coverage: Business (**B**); Key Person (**K**); or Personal (**P**).

Company	Face Amount	Policy Number	Issue Date *(mm/dd/yy)*	Replacement or Change of Policy?	1035 Exchange	Type
	$			☐ Yes ☐ No	☐ Yes ☐ No	
	$			☐ Yes ☐ No	☐ Yes ☐ No	
	$			☐ Yes ☐ No	☐ Yes ☐ No	
	$			☐ Yes ☐ No	☐ Yes ☐ No	
	$			☐ Yes ☐ No	☐ Yes ☐ No	
	$			☐ Yes ☐ No	☐ Yes ☐ No	

Please attach a list of any other additional insurance on a separate sheet. What is the total amount of new life insurance coverage that will be placed in force with all companies including this application? $ _____

SERVICE OFFICE ENDORSEMENTS *(For Company Use Only. We will attach additional documentation as needed.)*

TRUST VERIFICATION

I/We hereby certify that the Trustee(s) named in this application are the Trustee(s) for the named Trust, which is in full force and effect. The Company assumes no obligation to inquire into the terms of any trust agreement affecting this policy and shall not be held liable for any party's compliance with the terms thereof. The Company may rely solely upon the signature(s) of the Trustee(s) named in this application to any receipt, release or waiver, or to any transfer or other instrument affecting this policy or any options, privileges or benefits thereunder. Unless otherwise indicated, the signature(s) of all Trustee(s) named, or their successors, will be required to exercise any contractual right under the policy. The Company shall have no obligation to see to the use or application of any funds paid to the Trustee(s) in accordance with the terms of the policy. Any such payment made by the Company to the Trustee(s) shall fully discharge the Company with respect to any amounts so paid.

SUITABILITY - COMPLETE THIS SECTION IF VUL *ONLY*

1. Have you, the Proposed Insured and the Owner, received a current Prospectus, or equivalent document for the policy applied for and have you had sufficient time to review?	☐ Yes ☐ No
2. Do you understand that the amount and duration of the death benefit may increase or decrease depending on the investment performance of funds in the Separate Account?	☐ Yes ☐ No
3. Do you understand that the cash value may increase or decrease depending on the investment performance of the funds held in the Separate Account?	☐ Yes ☐ No
4. With this in mind, do you believe that the policy applied for is in accord with your insurance objective and your anticipated financial needs?	☐ Yes ☐ No

CASH VALUES MAY INCREASE OR DECREASE IN ACCORDANCE WITH THE EXPERIENCE OF THE SEPARATE ACCOUNT. THE DEATH BENEFIT MAY BE VARIABLE OR FIXED UNDER SPECIFIED CONDITIONS.

STATE DISCLOSURE

Any person who, with intent to defraud or knowing that he/she is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

AGREEMENT AND ACKNOWLEDGEMENT

Under penalties of perjury I, the undersigned, certify that: (a) the tax identification or social security numbers as provided by me is correct; and (b) the holders of said numbers are not subject to any backup withholding of U.S. Federal income tax.

Each of the Undersigned declares that:

1. This Application consists of: a) this Executive Benefits Individual Owner Part I and Part II Application; b) Part III Medical Application, if required; c) any amendments to the application attached thereto; and d) any supplements, all of which are required by the Company for the plan, amount and benefits applied for. This Executive Benefits Individual Owner Part I and Part II Application is fully completed.
2. I/We further agree that coverage will take effect under the Policy only when: 1) initial premium payment has been received; 2) the initial premium has been paid in full during the lifetime of the Proposed Insured; and 3) the Proposed Insured remains in the same state of health and insurability as described in each part of the application at the time conditions 1) and 2) are met.
3. If this is a request to exercise an option in an existing policy, the request will become effective in accordance with the terms of that option. If this is a request for change, any and all values may be used to pay for the change and to repay any loan indebtedness. The changed policy will be subject to any loan indebtedness not repaid. Any assignment in effect at the time of this request will apply to any new insurance issued.
4. No agent, broker or medical examiner has the authority to make changes or modify any Company contract or to waive any of the Company's requirements.
5. I HAVE READ, or have had read to me, the completed Application before signing. All statements and answers in this application are correctly recorded, and are full, complete and true. I confirm that upon receipt of the contract I will review the answers recorded on the application. I will notify the Company immediately if any information in the application is incorrect. Caution: If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or rescind coverage under the policy and any riders attached to it.
6. Corrections, additions or changes to this application may be made by the Company. Any such changes will be shown under "Service Office Endorsements". Acceptance of a policy issued with such changes will constitute acceptance of the changes. No change will be made in classification (including age at issue), plan, amount, or benefits unless agreed to in writing by the Applicant.

AUTHORIZATION

Each of the undersigned declares that:

I/We authorize any medical professional, hospital or other medical institution, insurer, MIB, Inc., or any other person or organization that has any records or knowledge of me or my physical or mental health or insurability to disclosure that information to the Company, its reinsurers or any other party acting on the Company's behalf. I/We authorize the Company or its reinsurer to make a brief report of my protected health information to MIB, Inc. I/We authorize the Company to disclose information related to my insurability to other insurers to whom I/we may apply for coverage.

I/We acknowledge receipt of the Privacy Notice and the Important Notice containing the Investigative Consumer Report and MIB, Inc. information.

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☐ I elect to be interviewed if an Investigative Consumer Report is prepared.

SIGNATORY SECTION

Signature of Proposed Insured **Date**

Signature of Applicant/Owner/Trustee **Date**

Signed at (City and State)

1) Based on information obtained from the Owner, I believe the investment is suitable for the Owner's objectives.
2) To the best of my knowledge, the source of funding for this policy does not include: (1) a non-recourse premium financing loan; or (2) any arrangement, other than a premium financing loan, which involves any person or entity with an interest in the potential for earnings based on the provision of funding for the policy.
3) Does the applicant have any existing life insurance policies or annuities? ☐ Yes ☐ No
4) Do you know or have you any reason to believe that replacement of insurance is involved? ☐ Yes ☐ No
   If a replacement is involved, I certify that only company approved sales materials were used in this sale and that copies of all sales materials were left with the applicant.

I declare that I have accurately answered all questions contained in this section.

I declare that I have provided each Proposed Insured and Owner(s) with the Important Notice as well as a copy of the Privacy Practices Notice.

Signature of Broker, Agent or Licensed Representative **Name of Broker, Agent or Licensed Representative** (Please Print) **Date**

Executive Benefits Corporate Owner Application for Life Insurance Part II Application

Lincoln Financial Group℠

B66_5-12
(Standard Version) **[B]**

The Lincoln National Life Insurance Company
Service Office: [350 Church St., - MEM4
Hartford, CT 06103-1106]
(hereinafter referred to as "the Company")

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(Please give a copy of these notices to the Proposed Insured.)

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All forms of insurance are based on the concept of risk-sharing. Underwriters seek to determine the level of risk represented by each applicant, and then assign that person to a group with similar risk characteristics. In this way, the risk potential can be spread among all policyholdersithin a gi ven risk group, assuring that each assumes his fair share of the insurance cost.

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Past experience shows that information from investigative reports usually does not have an adverse effect on our underwriting decision. If it should, we will notify you in writing and identify the reporting agency. At that point, if you wish to do so, you may discuss the matter with the reporting agency.

You have the right to be interviewed as part of any investigative consumer report that is completed. If you desire such an interview, please indicate this at the time your application is submitted. If you request it, we will supply the name, address and telephone number of the consumer reporting agency so you may obtain a copy of the report.

CONTESTABILITY

We strongly urge you to review the completed application closely for accuracy. During the 2 year incontestability period described in the policy, a claim may be denied if the application contains false statements or misrepresentations or fails to disclose material facts. In such a case, the policy could be void and coverage could be lost.

MIB, INC.

Information you provide regarding your insurability or claims will be treated as confidential except that The Company or its reinsurers, may make a brief report of it to MIB, Inc. This is a nonprofit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or submitted a claim, MIB, Inc. will provide the information it may have in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB at: [50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734]. You can reach MIB by phone toll free at [(866) 692-6901. (TTY {866} 346-3642)]

Lincoln Financial Group℠

The Lincoln National Life Insurance Company
Executive Benefits Corporate Owner Application
Part II Application
[350 Church St., - MEM4
Hartford, CT 06103-1106]

PROPOSED INSURED INFORMATION

1. Proposed Insured *(First, Middle Initial, Last)*			2. Place of Birth
3. Are you a citizen of the United States? ☐ Yes ☐ No (If "No", please provide country, type of visa, expiration date and green card information): _____			
4. Date of Birth *(mm/dd/yy)*	5. Social Security Number	6. ☐ Male ☐ Female	7. Driver's License # & State
8. Occupation		9. Salary $	10. Date of Hire *(mm/dd/yy)*
11. Home Address *(No., Street, PO Box, City, State, ZIP)*			
12. I have been notified by my employer that the maximum amount of insurance coverage that will be issued is: $_____ I understand that this form, or a copy of this form, will be given to the Owner and included as part of the policy/contract.			

GENERAL RISK INFORMATION For Proposed Insured

If you answer "No" to question 13, or "Yes" to questions 15-19, explain in the space provided on Page 2.

13. Have you been actively at work daily on a full-time basis (30 hours/week) performing all duties of your regular occupation, at your customary place of employment for the past 3 months? (Disregard vacation days, normal non-working days and absences that total less than 4 consecutive days.)	☐ Yes ☐ No
14. Have you ever used tobacco or products containing nicotine (including, but not limited to, chew tobacco, snuff, nicotine gum and/or patches)? *(If "Yes", list below.)*	☐ Yes ☐ No

Type	Date First Used: *(month/year)*	Date Last Used: *(month/year)*	Amount and Frequency:

15a. Do you now, or do you plan to fly, or have you flown during the past 2 years, as a pilot, student pilot or crew member? *(If "Yes", an Aviation Supplement is required; this includes balloon pilots.)*	☐ Yes ☐ No
b. Do you plan to participate, or have you participated within the past 2 years; in motor vehicle or boat racing, in hang gliding, sky or scuba diving, or mountain, rock or technical climbing; or in similar sports? *(If "Yes", an Avocation Questionnaire is required.)*	☐ Yes ☐ No
c. Do you now, or do you plan to reside or travel outside of the United States or Canada within the next year? *(If "Yes", a Foreign Travel or Residence Questionnaire is required.)*	☐ Yes ☐ No
16. In the past 5 years, have you been convicted of two or more moving violations, driving under the influence of alcohol or other drugs, or had your license suspended, revoked or restricted? *(If "Yes", please provide what type and dates in the "Details" space provided.)*	☐ Yes ☐ No
17. Have you ever applied for any life, health or disability insurance which was denied, postponed, required an extra premium or was issued for a reduced amount? *(If, "Yes", please provide what type and dates in the "Details" space provided.)*	☐ Yes ☐ No
18. Have you ever been convicted or are you waiting trial for a felony? *(If "Yes", please indicate type, date and city/state of felony and if currently on probation or parole.)*	☐ Yes ☐ No
19. Are you a member of, or applied to be a member of, or received a notice of required service in, the armed forces, reserves or National Guard? *(If "Yes", please indicate if Retired or active; list branch of service, rank, duties, mobilization category and current duty station; if a notice of deployment has been received, to where and when; in the "Details" space provided.)*	☐ Yes ☐ No

GENERAL RISK INFORMATION For Proposed Insured (Continued)

20. **Details:** *(If you answered "No" to question 13, or "Yes" to questions 15-19 list details in this section; please include question number details pertain to and attach an additional sheet of paper, if necessary.)*

MEDICAL RISK INFORMATION For Proposed Insured

If you answer "Yes" to any of the following questions, please provide further information in the "Details" space provided on page 3.

21. **Have you ever had an indication of, or been treated by a licensed medical professional for:**	**Yes**	**No**
a. Chest pain, palpitations, high blood pressure, heart disease, heart murmur, heart failure or other disorders of the heart or blood vessels?	☐	☐
b. Any tumor, cancer, cysts, melanoma, lymphoma or any disorder of the lymph nodes?	☐	☐
c Anemia, leukemia, clotting disorder or any other blood disorder?	☐	☐
d. Diabetes, elevated blood sugar, thyroid, or other endocrine or glandular disorder?	☐	☐
e. Asthma, emphysema, allergies, sleep apnea, tuberculosis, sarcoidosis, persistent hoarseness or shortness of breath or any other disorder of the respiratory system?	☐	☐
f. Seizures, fainting, dizziness, epilepsy, stroke, paralysis or other neurologic or brain disorder?	☐	☐
g. Any nervous, mental, or emotional disorder, or received counseling for anxiety, depression, stress or any other emotional condition?	☐	☐
h. Ulcers, colitis, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disorder of the stomach, esophagus, liver, intestines, gallbladder, or pancreas?	☐	☐
i. Any complication of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney or urinary bladder?	☐	☐
j. Arthritis, gout or any disorder of the back, spine, muscles, nerves, bones or joints or skin?	☐	☐
k. Any disorder of the eyes, ears, nose or throat?	☐	☐
l. Any mental or physical disorder medically or surgically treated condition not listed above?	☐	☐
22. Have you ever been diagnosed as having or been treated by a licensed medical professional for Acquired Immune Deficiency Syndrome or an AIDS related condition?	☐	☐
23. Do you use alcoholic beverages? *(If "Yes", Provide type, Frequency & Amount)* Type _____ Frequency _____ Amount _____	☐	☐
24. Have you ever been treated for drug or alcohol abuse or been advised by a licensed medical professional to limit your use of alcohol or any medication, prescribed or not?	☐	☐
25. In the past 5 years have you ever used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics?	☐	☐
26. Have you had or been advised by a licensed medical professional to have a check-up, EKG, x-ray, blood or urine test or any other diagnostic test or are you now planning to seek medical advice or treatment for any reason?	☐	☐
27. Have you been a patient in a hospital, clinic, sanatorium or other medical facility, or been advised by a licensed medical professional to have any hospitalization or surgery which has not been completed?	☐	☐

28. List all medication and dosages you are currently taking or have taken in the last 30 days, including prescriptions, over the counter drugs, aspirin and herbal supplements: *(Attach an additional sheet of paper, if necessary.)*

DETAILS TO MEDICAL RISK INFORMATION QUESTIONS 23-29, if answered "Yes", please specify below.

29. Number, nature and severity of condition, frequency of attacks, treatments received medication, dates, name, address & phone number of medical attendants and hospitals. Details (List details from "Yes" answered Medical Information; please include question number.) *(Attach an additional sheet of paper, if necessary.)*

Ques.	Details

MEDICAL INFORMATION For Proposed Insured

30 a. Provide full name/address/phone number of personal physician(s) and any other physicians seen within the past 5 years. *(Attach an additional sheet of paper, if necessary.)*

b. Date and reason of last visit:

c. Tests performed & treatment received:

31. Height _____ ft. / _____ in. a. Has your weight changed by more than 10 pounds during the past 12 months? ☐ Y ☐ N
Weight _____ lbs. b. If "Yes," by how many pounds? _____ ☐ Gain ☐ Loss

32.	Age if Living & Health Status	Diabetes, Cancer, Heart Disease? *(include age of onset)*	Age at Death & Cause
a. Father			
b. Mother			
c. Sibling(s)			

OTHER INSURANCE

33. Are you considering stopping premium payments, surrendering, replacing, forfeiting, assigning to the insurer or reducing your benefit under an existing policy or annuity, or are you considering using or borrowing funds from your existing policies or annuities to pay premiums due on the new or applied for policy? ☐ Yes ☐ No _____

(If "Yes", please complete and sign all replacement forms.)

34. Amount of other Corporate Sponsored life insurance presently in force or applied for: **If none, check this box:** ☐
Please indicate the Type of coverage: Business (**B**); Key Person (**K**)

Company	Face Amount	Policy Number	Issue Date *(mm/dd/yy)*	Replacement or Change of Policy?	1035 Exchange	Type
	$			☐Y ☐N	☐Y ☐N	
	$			☐Y ☐N	☐Y ☐N	
	$			☐Y ☐N	☐Y ☐N	
	$			☐Y ☐N	☐Y ☐N	
	$			☐Y ☐N	☐Y ☐N	
	$			☐Y ☐N	☐Y ☐N	
	$			☐Y ☐N	☐Y ☐N	
	$			☐Y ☐N	☐Y ☐N	
	$			☐Y ☐N	☐Y ☐N	
	$			☐Y ☐N	☐Y ☐N	
	$			☐Y ☐N	☐Y ☐N	

Please attach a list of any other additional insurance on a separate sheet. What is the total amount of new life insurance coverage that will be placed in force with all companies including this application? $ _____

[BENEFICIARY DESIGNATION

35. Individual *(Provide Full Name, Social Security Number and Relationship)*

Primary _____ _____ % SSN: _____ Relationship to Insured: _____

Address *(Street, City, State, ZIP)* _____

Primary _____ _____ % SSN: _____ Relationship to Insured: _____

Address *(Street, City, State, ZIP)* _____

36.

Contingent _____ _____ % SSN: _____ Relationship to Insured: _____

Contingent _____ _____ % SSN: _____ Relationship to Insured: _____

SERVICE OFFICE ENDORSEMENTS *(For Company Use Only. We will attach additional documentation as needed.)*

AGREEMENT AND ACKNOWLEDGEMENT

Each of the Undersigned declares that:

1. This Application consists of: a) this Executive Benefits Individual Owner Application - Part I and Part II; b) Part III Medical Application, if required; c) any amendments to the application attached thereto; and d) any supplements, all of which are required by the Company for the plan, amount and benefits applied for. This Application for Life Insurance - Part I and Part II is fully completed.
2. I/We further agree that coverage will take effect under the Policy only when: 1) initial premium payment has been received; 2) the initial premium has been paid in full during the lifetime of the Proposed Insured; and 3) the Proposed Insured remains in the same state of health and insurability as described in each part of the application at the time conditions 1) and 2) are met.
3. If this is a request to exercise an option in an existing policy, the request will become effective in accordance with the terms of that option. If this is a request for change, any and all values may be used to pay for the change and to repay any loan indebtedness. The changed policy will be subject to any loan indebtedness not repaid. Any assignment in effect at the time of this request will apply to any new insurance issued.
4. No agent, broker or medical examiner has the authority to make changes or modify any Company contract or to waive any of the Company's requirements.
5. I HAVE READ, or have had read to me, the completed Application for Life Insurance before signing. All statements and answers in this application are correctly recorded, and are full, complete and true. I confirm that upon receipt of the contract I will review the answers recorded on the application. I will notify the Company immediately if any information in the application is incorrect. Caution: If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or rescind coverage under the policy and any riders attached to it.
6. Corrections, additions or changes to this application may be made by the Company. Any such changes will be shown under "Service Office Endorsements". Acceptance of a policy issued with such changes will constitute acceptance of the changes. No change will be made in classification (including age at issue), plan, amount, or benefits unless agreed to in writing by the Applicant.

STATE DISCLOSURE

Any person who, with intent to defraud or knowing that he/she is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

AUTHORIZATION

The undersigned declares that:

I authorize any medical professional, hospital or other medical institution, insurer, MIB, Inc., or any other person or organization that has any records or knowledge of me or my physical or mental health or insurability to disclosure that information to the Company, its reinsurers or any other party acting on the Company's behalf. I authorize the Company or its reinsurer to make a brief report of my protected health information to MIB, Inc. I authorize the Company to disclose information related to my insurability to other insurers to whom I may apply for coverage.

I acknowledge receipt of the Privacy Notice and the Important Notice containing the Investigative Consumer Report and MIB, Inc. information.

This authorization shall be valid for 24 months after it is signed. A photographic copy of this authorization shall be as valid as the original. I understand that I may revoke this authorization at any time by written notification to the Company; however, any action taken prior to notification will not be affected.

The purpose of this authorization is to allow the Company to determine eligibility for life coverage or a claim for benefits under a life policy.

☐ I elect to be interviewed if an Investigative Consumer Report is prepared.

SIGNATORY SECTION

Signed in _____ (city), _____ (state), this _____ day of _____ (month) _____ (year)

_____ **Signature of Proposed Insured**

_____ **Witness**

The Lincoln National Life Insurance Company
Executive Benefits
[350 Church St., - MEM4
Hartford, CT 06115-0482]

IMPORTANT NOTICE
Since you are applying for insurance, we would like you to know more about our underwriting process and what occurs after you submit your application.

(Please give a copy of these notices to the Proposed Insured.)

THE UNDERWRITING PROCESS

All forms of insurance are based on the concept of risk-sharing. Underwriters seek to determine the level of risk represented by each applicant, and then assign that person to a group with similar risk characteristics. In this way, the risk potential can be spread among all policyholders within a given risk group, assuring that each assumes his fair share of the insurance cost.

Underwriters collect and review risk factors such as age, occupation, physical condition, medical history and any hazardous avocations. The level of risk and premium for the amount of coverage requested is based on this information.

INVESTIGATIVE CONSUMER REPORT

As a part of our routine procedure for processing your initial application, we may request an investigative consumer report. The agency making the report may keep a copy of the report and disclose its contents to others for whom it performs similar services. The report typically includes information such as identity and residence verification, character, reputation, marital status, estimate of net worth and income, occupation, avocations, medical history, habits, mode of living and other personal characteristics. Additional information is usually obtained from several different sources. Confidential interviews are conducted with neighbors, friends, business associates, and acquaintances. Public records are carefully reviewed.

Past experience shows that information from investigative reports usually does not have an adverse effect on our underwriting decision. If it should, we will notify you in writing and identify the reporting agency. At that point, if you wish to do so, you may discuss the matter with the reporting agency.

You have the right to be interviewed as part of any investigative consumer report that is completed. If you desire such an interview, please indicate this at the time your application is submitted. If you request it, we will supply the name, address and telephone number of the consumer reporting agency so you may obtain a copy of the report.

CONTESTABILITY

We strongly urge you to review the completed application closely for accuracy. During the 2 year incontestability period described in the policy, a claim may be denied if the application contains false statements or misrepresentations or fails to disclose material facts. In such a case, the policy could be void and coverage could be lost.

MIB, INC.

Information you provide regarding your insurability or claims will be treated as confidential except that The Company or its reinsurers, may make a brief report of it to MIB, Inc. This is a nonprofit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or submitted a claim, MIB, Inc. will provide the information it may have in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB, Inc.'s file, you may contact MIB at: [50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734]. You can reach MIB by phone toll free at [(866) 692-6901. (TTY {866} 346-3642)]

The Lincoln National Life Insurance Company
Executive Benefits
[350 Church St., - MEM4
Hartford, CT 06115-0482]

MODIFIED SIMPLIFIED UNDERWRITING AND CONSENT FORM

☐ **Yes** - I, _____ (please print), consent my employer _____

LLC or any grantor trust it may establish, (the "Owner") obtaining life insurance policies (the "Policies") on my life.

I acknowledge that the Owner has an insurable interest in my life and I further acknowledge that the Policies will be used to informally fund benefit obligations. I understand and agree that the Owner named above will be the sole owner and beneficiary of the Policies and that neither I, myself nor any beneficiary I may designate shall have any interest in the Policies or a right to the proceeds thereof. I understand that the Policies are being acquired by the Owner for its own benefit in connection with informally funding Company benefit liabilities.

I understand that, in order to informally fund benefit obligations, the Owner may need to increase the amount of insurance under existing Policies on my life from time to time. I hereby authorize the Owner to affect such an increase or increases without providing any further notice to me. I also consent to an authorize the Owner to ntinue to be the owner and beneficiary of the Policies indefinitely, including after my employment with the Company terminates, whenever and for whatever reason this may occur.

I have been notified by my employer that the maximum amount of insurance issued on my life may vary but the maximum amount will not exceed $ _____.

I understand that this form, or a copy of this form, will be given to the Owner and included as part of the policy/contract.

☐ **No** - I do not consent to have life insurance purchased on my life.

Work Status: (Please complete)

1. Have you been actively at work daily on a full-time basis (at least 30 hours/week) performing all duties of your regular occupation, at customary place of employment for the past 3 months? (Disregard vacation days, normal non-working days and absences that total less than 4 consecutive days.) If "No", specify:	☐ Yes ☐ No
2. Have you ever used tobacco or products containing nicotine (including, but not limited to, chew tobacco, snuff, nicotine gum and/or patches)? (If "Yes", list below):	☐ Yes ☐ No

Type	Date First Used: *(month/year)*	Date Last Used: *(month/year)*	Amount and Frequency:

3. Have you, in the past 10 years been treated for any disorder of the heart or blood vessels, tumors or cancer, diabetes, stroke or any disorder of the blood, lungs, kidneys, drug or alcohol use, depression or been diagnosed or treated by a doctor or other medical practitioner for Acquired Immune Deficiency (AIDS) or AIDS related condition? If "Yes", specify:	☐ Yes ☐ No

AUTHORIZATION

The undersigned declares that:

I authorize any medical professional, hospital or other medical institution, insurer, MIB, Inc., or any other person or organization that has any records or knowledge of me or my physical or mental health or insurability to disclosure that information to the Company, its reinsurers or any other party acting on the Company's behalf. I authorize the Company or its reinsurer to make a brief report of my protected health information to MIB, Inc. I authorize the Company to disclose information related to my insurability to other insurers to whom I may apply for coverage.

I acknowledge receipt of the Privacy Notice and the Important Notice containing the Investigative Consumer Report and MIB, Inc. information.

This authorization shall be valid for 24 months after it is signed. A photographic copy of this authorization shall be as valid as the original. I understand that I may revoke this authorization at any time by written notification to the Company; however, any action taken prior to notification will not be affected.

The purpose of this authorization is to allow the Company to determine eligibility for life coverage or a claim for benefits under a life policy.

☐ I elect to be interviewed if an Investigative Consumer Report is prepared

STATE DISCLOSURE

Any person who, with intent to defraud or knowing that he/she is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

INSURED INFORMATION

1. Proposed Insured *(First, Middle Initial, Last)*		2. ☐ Male ☐ Female
3. Social Security Number	4. Date of Birth *(mm/dd/yy)*	5. Are you a citizen of the United States? ☐ Yes ☐ No (If "No", please provide country, type of visa, expiration date and green card information): _____
6. Date of Hire *(mm/dd/yy)*	7. Salary $	
8. Work Address *(Street, City, State/Country, ZIP)*		

[BENEFICIARY DESIGNATION

9.
Primary _____ _____ % SSN:_____ Relationship to Insured:_____

Address *(Street, City, State, ZIP)*_____

Primary _____ _____ % SSN:_____ Relationship to Insured:_____

Address *(Street, City, State, ZIP)*_____

10.
Contingent_____ _____ % SSN:_____ Relationship to Insured: _____

Contingent_____ _____ % SSN:_____ Relationship to Insured: _____]

Signature of Proposed Insured **Date**

SERFF Tracking Number:	*LCNC-128350390*	*State:*	*Arkansas*
Filing Company:	*The Lincoln National Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*B62_5-12, B63_5-12, B66_5-12, B10494_5-12*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*MIB update (COLI APPLICATIONS AND CONSENTS)*		
Project Name/Number:	*MIB update (COLI APPLICATIONS AND CONSEN/B62_5-12, B63_5-12, B66_5-12, B10494_5-12*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachment:

AR_LNL_Readability.pdf

Item Status: **Status Date:**

Bypassed - Item: Application

Bypass Reason: Please see form schedule tab.

Comments:

Arkansas

READABILITY CERTIFICATION

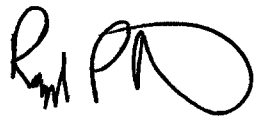
The Lincoln National Life Insurance Company

Re:

B62_5-12 – Executive Benefits Individual Owner Modified Simplified Issue Part I Application for Life Insurance
B63_5-12 – Executive Benefits Individual Owner Part I and Part II Application for Life Insurance
B66_5-12 – Executive Benefits Corporate Owner Application for Life Insurance Part II Application
B10494_5-12 – Modified Simplified Underwriting and Consent Form

We hereby certify that the attached Form(s) is (are) in compliance with the Rules and Regulation requirements regarding Life, Annuities, and Accident and Sickness Insurance Language Simplification Standards and has (have) achieved a Flesch Reading Ease score of:

Form Number	***Flesch***
B62_5-12 – Executive Benefits Individual Owner Modified Simplified Issue Part I Application for Life Insurance	50
B63_5-12 – Executive Benefits Individual Owner Part I and Part II Application for Life Insurance	50
B66_5-12 – Executive Benefits Corporate Owner Application for Life Insurance Part II Application	50
B10494_5-12 – Modified Simplified Underwriting and Consent Form	52



Raymond P. Fortier, Assistant Vice President
Product Compliance

Date: May 11, 2012